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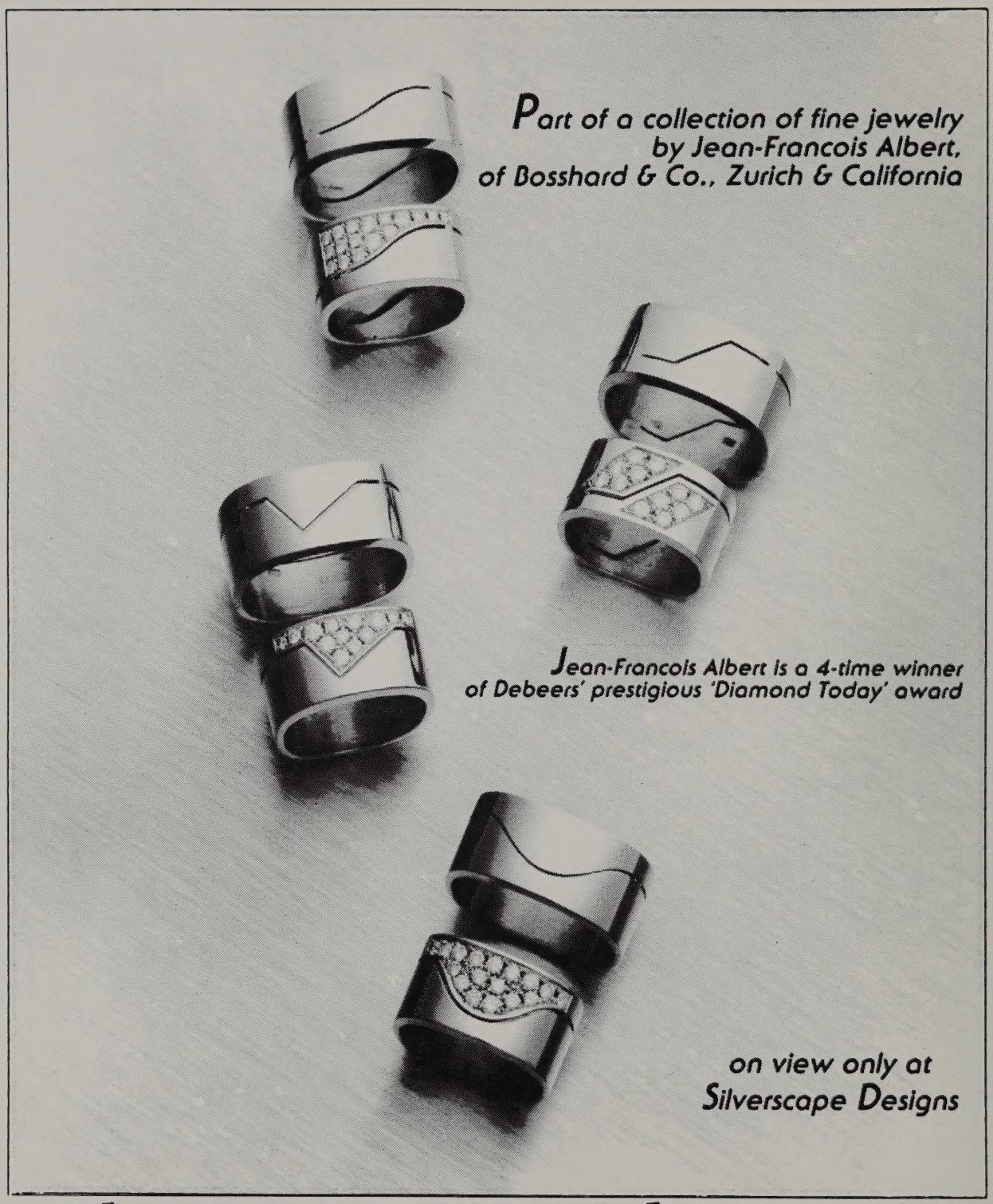
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THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 8
FEBRUARY - MARCH 1986

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THE HAMPDEN HIPPOCRAT

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VOLUME XXXXII NO. 8

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HDMS President's Message

Augusto G. Asinas, M.D., President

The year 1985 has been a very exciting year for all of us. There have been rapid changes taking place in the practice of medicine. In the forefront is still the malpractice issue. Much as been said in the press and the media for and against this issue. I would like to thank all of you who have contributed much of your time and energy in the malpractice fight. It is far from being over. There is much to be done in the coming year. Both the Massachusetts Medical Society and the Governor have reintroduced the malpractice tort reform bill in the legislature for this year. We should not relent in our effort to bring about a fair and equitable tort reform.

I find it very refreshing to know in my neurosurgical practice that there are many individuals who expressed willingness to lend their support for our cause. I am sure you will find the same in your practice. It is increasingly important for all of us to enlist the support of our individual patients, business colleagues and hospital trustees. We have to make it clear to them that this will definitely have an impact on the future of the medical practice and the quality of health care.

One of our fellow physicians has been singled out for discriminating against a medicaid recipient. This comes at a very bad time when the Medical Society is trying very hard to enroll as many physicians in the state medicaid program as possible. As you all know, the agreement signed between the Governor and the Massachusetts Medical Society called for at least 85% participation by the physicians throughout the state. There is much need for surgical specialities to join the program. However in the light of these new developments we will have to work harder to obtain this goal.

The Medical Society would like to ask the membership for their support in the defense of our colleague. A fund is being set up by the society for this purpose. Any contributions will be much appreciated from our fellow physicians. It is high time for all of us to stand up and be counted!

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Medicine Through The Years

by Margaret, Stoler, Springfield Academy of Medicine

In conjunction with the 1986 Physician Portrait Fund Drive, a series of articles will appear in the Hippocrat giving an overall view of the development of medicine from the colonial period to the present.

1836-1886

The most remarkable development in the field of medicine during the 1836-1886 period was the increase in the number of schools. From 1810 to 1860 there was a 66% increase over the previous fifty years and from the immediate post Civil War period to 1890, there was a 75% increase.

The rise in the number of medical schools caused a decline in the standard of education. Originally, Yale Medical School, established in 1813, required six months instruction but with the increase in competition, decreased the term to four months in 1856. All that was needed to establish a medical school was a lecture hall and several lecturers. A survey of thirty schools in 1849 revealed that only four required certification of three years apprenticeship, nineteen required some apprenticeship and seven, no apprenticeship at all. The AMA, in lieu of apprenticeship, instituted preliminary standards for those entering medical school requiring that students have a good education in English, natural philosophy, mathematics and an "acquaintence with latin and Greek." This approach was wholly unrealistic since only Massachusetts provided a public education system at that time.

With no set standards for medical education, the caliber of schools varied widely. Students could enter very late in the semester and leave very early. Written exams were nominal and an oral quiz with each professor rarely lasted longer than five to ten minutes. Terms lasted from November thru March, requiring two successive sessions and an additional year's reading in a physician's office. Urban medical schools opened free clinics for teaching purposes, much to the indignation of practicing physicians who claimed they were stealing patients who might otherwise have been theirs.

Up to the 1870's medical schools attached to universities hesitated to raise their requirements due to the strong competition, but in 1871, Harvard took the plunge, demanding three years of graded curriculum with nine month terms. The same year eight other university medical schools complied as well as two homeopathy schools. The increase in educational institutions precipitated a quarrel which had been festering in the medical community for many years; the question as to who had the right to license.

Originally physicians, themselves, would give their apprentices certificates. As villages expanded into towns, Boards of Censors were established to exam and license. In 1778, Harvard College proceeded to challenge that right by sending two graduates to the Board of Censors to be examined and licensed to practice medicine. The Board, out of fear of reprecussions from the Mass. Medical Society who also maintained the right to license, refused. Anticipating such action, Harvard set up extended courses in dissection and the following year, conferred Doctor of Physic degrees upon the two students, opening the door for any so called medical institution to license at will. In the chaos following the Civil War, anyone could set up shop and practice medicine. One such case was "Dr. Allan" who had no medical degree but carried on a large practice in rural Louisana. When, in 1894, charges were brought against him for practicing medicine, he decided to close his practice. Confronted with the outrage of the citizenry, the grand jury withdrew its indictment and the man continued to practice medicine until 1920.

Competition, which usually acts as a stimulus towards "building a better mouse trap," worked in reverse in the field of medicine. The unscientific nature of medicine at this time made it possible to prove the validity of any therapy. Frequently, if a patient summoned a second opinion, the new doctor immediately insisted on discarding all the medicines previously prescribed. Rural physicians rarely had a problem with competition, yet they had to contend with being paid once a year when the crops came in. Usually they depended on a small crop of their own to keep food on the table. The only doctors assured of payment where those in the South who contracted with plantation owners to maintain the health of their slaves, a system very similar to the present day Health Maintenance Organizations. Unfortunately, the competition reflected a growing animosity within the medical community that tarnished the image of the profession as a whole. As early as 1835 the following appeared in the *New York Chronicle of Medicine and Surgery:*

> "...no body of men are less in concert or seem less influenced by the 'esprit de corps' than physicians...the quarrels of physicians are proverbially frequent and bitter and their hatred, intensity and duration seem to exceed that of other men. This state of things is in some degree attributable to the nature of the profession."

Discord not only existed between individual physicians but also within medical societies, themselves. Twice in 1848 physicians from Western Massachusetts broke away from the Mass. Medical Society when the issue of fee standards was addressed. Originally Mass. Medical Society, which was established in 1780, was exclusive to Boston physicians only but in 1781, it was open to "eminent physicians throughout the state," but limited to seventy "charter members".

The New York Medical Society, in 1844, tried to raise the standards of medical schools within the state, but the schools

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Medicine Through The Years

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claimed they would lose students to surrounding medical schools. The leaders of the society realized that only with a nationwide establishment could standards improve. Again in 1846, a meeting was held including members and delegates from the major medical colleges in the union. Very few attended, fearing the motives of those calling the meeting. In 1847 a Convention was held in Philadelphia which included delegates from all medical colleges, medical societies, insane asylums, hospitals and boards of health. Standards were set regarding preliminary education of apprentices, examinations by preceptors and the number of years of apprenticeship, and that only those attending approved schools would be recognized by the newly established American Medical Association.

One of the major objectives for establishing the AMA was to undermine public opinion towards homeopathy. Dr. Charles Coventry, a Charter member and one of the outstanding professors during this period, wrote "...the first great step then should be to draw a line of demarcation between those who are of the profession and those who are not...(through) the formation of a national association...Let a system of medical ethics be established by the national society and signed by every member." The Code of Ethics includes the following resolution:

> "...No one can be considered as a regular practitioner or a fit associate in consultation whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession, and of the aids actually furnished by anatomy, physiology, pathology and organic chemistry."

By 1874 membership to AMA was limited to state medical societies and other societies recognized by the state societies.

With the increase in urban population occurring in the mid-nineteenth century came a greater opportunity to specialize. In opposition, the general practitioners recommended to the AMA that specialists be ostracized, claiming they were "no better than charlatans using secret nostrums" and preyed on the city poor by opening up free clinics and public infirmaries, using them as guinea pigs to experiment upon. In 1875 the Medical Society of New York deplored specialization, claiming the tendency was to specialize before becoming competent practitioners, purely for financial reasons. The same society, five years later, conceded that "the progress of medicine depends on the continued efforts of specialists". A comment printed in the *New York Chronicle of Medicine and Surgery* in 1880 sums up the changes taking place:

> "Thirty years ago the Chair of Obstetrics included Diseases of Women and Children...Now there are delivered some thirty or forty lectures on obstetrics and some thirty or forty more on Diseases of Women and the subject of disease of Children is turned over to another professor."

Dr. William Brodie, President of the AMA in 1886, stated in his address to the membership that "by devoting themselves to one branch instead of working up a general practice, they could often do more good, earn more money and have less arduous work to perform." Specialists, however, established their own societies, claiming that the AMA was too inept and did not truely serve their needs. Dr. Abraham Jacobi, twice president of the AMA, stated that specialty societies were founded by physicians "who had no time to spare for entertainment, excursions, medico-political wrangling and other pastimes."

The first specialty to establish its own society was ophthalmology which founded the American Ophthalmological Society in 1864. By 1886 seven more specialty societies were established, including otolaryngology, neurology, dermatology, gynecology, laryngology, surgery and the genitourinary society.

A major reason for the advances in specialization was the invention and improvement of several medical instruments. The microscope, which was invented in the early 17th century, was of little use to the physician until the early 1800's when effective specimen preparation techniques were developed. So too, the germ theory was not yet readily accepted. As late as 1902 one leading physician wrote:

> "Do not allow yourself to be biased too quickly or too strongly in favor of new theories based on physiological, microscopical, chemical or other experiments, especially when offered by the unbalanced to establish their abstract conclusions or preconceived notions, or by those who have blindly identified with the latest medical novelty".

What can be considered the greatest advance in medicine during this period was the discovery of ether. Until the

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1840's, the only means of reducing pain was opium, hemp, hashish and whiskey. Unfortunately, tragedy surrounds the three major characters involved in the discovery. There was a fourth physician, Dr. Crawford W. Long of Jefferson, Georgia, who observed the effects of nitrous oxide, "laughing gas", at many parties he attended during his training at various hospitals in New York City during 1841. Upon returning home to Georgia he removed a small neck tumor as well as amputating a toe using "laughing gas" in 1842 with no signs of pain in either patient. Unfortunately he did not publish his findings until 1849. Fortunately, he lived a long and productive life, unincumbered by the pain and frustration that confronted the other three physicians; Dr. Horace Wells, Dr. William Morton and Dr. Charles Jackson.

In 1844, Dr. Horace Wells, a young dentist in Hartford, Conn., witnessed a demonstration of nitrous oxide. One of the participants of the demonstration accidentally fell off the platform and seemed to experience no pain. The following day, he asked his assistant to administer a little of the substance before pulling one of Wells's teeth. Convinced that nitrous oxide killed pain, he contacted his former partner in Boston, Dr. William Thomas Green Morton. Morton arranged for Wells to give a demonstration in front of a group of medical sudents. Unfortunately, the experiment failed and Wells was booed by the spectators. Mortified, he returned to Hartford and after further experiments, was arrested for unruly behavior and committed suicide in 1848.

Dr. Morton, fascinated with the possibilities of painless medicine, contacted his preceptor, Dr. Charles A. Jackson, a leading physician, chemist, and geologist, regarding his recommendations for lessening pain. Jackson recommended the use of a drop of sulfuric ether to the gums before extraction. Morton began experimenting and several months later, arranged with Dr. John Warren to demonstrate his discovery at the Mass. General Hospital. The operation, which was the removal of a tumor from the neck of patient George Abbott, was performed in what is now called the Ether Dome, and was successful. Morton immediately published his findings in a Boston newspaper.

Shortly after, Dr. Jackson wrote to the French Academy of Science, claiming Morton had robbed him of his discovery. He made similar statements before the American Academy of Arts and Sciences. Though Jackson knew of the effects of ether, he never took on the responsibility of demonstrating it and had Morton's patient died, Jackson would have been the first to condemn him.

Morton, having gained nothing from his patient, appealed to Congress to give him a suitable reward. A bill to award Morton $10,000 for the discovery of ether was introduced to Congress, and brought a strong protest from the Senator from Georgia, who claimed that Dr. Crawford Long was the discoverer. Claims and counter-claims continued until 1863 when Congress dropped the whole issue.

Morton continued his battle for recognition for another five years until he died of a stroke in 1868, supposedly brought on by reading one of Jackson's attempts to undermine his position.

In 1873, Jackson was committed to a mental hospital where he died seven years later.

The effects of the discovery of ether were widespread. According to the records of the Mass. General Hospital, surgical procedures increased 66% in 1850 over those performed in 1820. Before the end of 1846, ether was being used regularly in London and Paris.

In 1848, a British doctor introduced the use of chloroform in his obstetrical practice in London. Dr. Charles Meigs, an outstanding obstetrician in Philadelphia, was outraged, claiming the pain of childbirth was part "of those Natural and Physiological forces that Divinity has ordained us to enjoy and suffer." Its uncertain what he meant by "us". Women around the world ignored the remonstrations of both the church and Dr. Meigs. In 1856, Dr. John Metcalf submitted a paper to the Mass. Medical Society, which sums up the role of chloroform in childbirth. He wrote: "in every case, if I am called to a succeeding labor, the first question has invariably been 'Have you brought the chloroform?'".

Aside from the discovery of ether and the development of specialization, another great accomplishment was made in the field of medicine during this period, but not without a struggle; the acceptance of women in medicine.

After having studied medicine under the guidance of Dr. Joseph Warrington, Elizabeth Blackwell began applying to medical schools, none of which ever bothered to reply. In 1847, she applied to the Geneva College of Medicine in upstate New York. The president, who greatly admired Dr. Warrington, decided to turn the decision over to the faculty, who, unable to come to a decision, turned it over to the unruly student body, most of whom were the sons of local farmers and did not take to study easily. The students were delighted with the prospect of some sort of diversion and "pledged that no conduct of ours shall cause her to regret her attendance at this institution." Years later, Dr. Stephan Smith, a classmate, wrote: "For the first time a lecture was given without the slightest interruption...The sudden transformation of the class from a band of lawless desperadoes

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Medicine Through The Years

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to gentlemen by the mere presence of a lady, proved to be permanent in its effect." Unfortunately, she was the exception. The following year her sister applied and was refused admittance. Not until 1865 were other women accepted.

In 1850, Dean O.W. Holmes, father of the famous jurist, submitted the name of Dr. Harriot K. Hunt, who practiced medicine without a license, to Harvard College. No statue was found denying women but the student body countered with two strongly stated resolves:

> "1. That no woman of true delicacy would be willing in the prescence of (sic) of men to listen to the discussion of subjects that come under consideration of the student of medicine.
> 2. That we object to having the company of any female forced upon us, who is disposed to unsex herself and to sacrifice her modesty by appearing with men in the lecture room."

No woman was admitted to Harvard Medical School until 1945!

In 1857, Dr. Blackwell opened the New York Infirmary for Poor Women and Children. Angry mobs stormed the hospital due to the fact it was run entirely by women, but with strong Quaker support, it survived and in 1868, she established a Women's Medical College. The first medical college to confer MD degrees on women was the New England Female Medical College which was chartered in 1856. Yet in 1872, the new president of the AMA, Dr. David W. Yandell, stated in his acceptance speech: "I defend the right of women to practice medicine but hope they will never embarrass us by a personal application for seats in the association." Not until 1915 were women admitted to membership.

At the outbreak of the Civil War, the entire U.S. Army Medical Department was less than five hundred. The South had to begin from scratch. When the war began, it was expected to last only a few months but by April 1862, the Sanitary Commission, forerunner of the Red Cross, recommended that the entire Medical Department be revised. By the end of 1862, there were one hundred and fifty general hospitals, with 58,715 beds. Both figures would double by the end of the war.

Dr. William Hammond was appointed Surgeon General of the Union forces and recommended that a permanent hospital be established in Washington, that an Army Medical School be established as well as an Army Transportation Department, and appropriation be made available to establish a Medical Museum. (Its interesting that at the beginning of a war, appropriation was proposed to remember those that were about to die.) Dr. Samuel Moore was appointed by the Confederate Army to serve as Surgeon General.

Aside from the designated base hospitals to be made available in all major cities in the North, field hospitals were to be created at various sites along the railroad system. Churches and private homes were also required to take in wounded. Field hospitals would be set up as close to the battle line as possible. Frequently, the physician would attend those too seriously wounded to move on the battlefield. Orderlies would assist the doctor in the field by carrying the "hospital knapsack" which could weigh upwards of 20 pounds. Removing those from the battlefield would sometimes take up to three days. The wounded would be carried off on horsedrawn carts to the field hospital, then by train to the nearest base hospital.

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Base hospitals were rampant with small pox, measles, and dysentery. Although early in the war, Dr. Hammond demanded the removal of calomel from all supply tables, the order went wholly unnoticed since calomel was regarded as having "the power of subduing all manner of contagion, and infections including syphilis, itch, smallpox, measles and early stages of jail fever".

Dressings were few and scanty. Medicines were mostly in pill form. Infections were the major problem since more often than not the same basin of water was used to wash the wounds of several patients. For amputations which were done within 24 hours to reduce the chance of infection, chloroform or opium pills were administered.

Most of the hospital staff were enlisted men who would be relieved of hospital duty when a convalescing patient could take over. In the North, women eagerly volunteered, but in the South, tradition did not encourage "ladies to venture into what was considered a man's world".

The surgical experience gained during the Civil War could be considered the beginnings of surgery as a specialty. However, as late as 1876, Dr. Samuel Gross, an eminent surgeon, stated that it was "safe to affirm that there is not a medical man on this continent who devotes himself exclusively to the practice of surgery."

One other aspect of medicine was introduced during the Civil War and that was the state of neutrality for all aspects of the Medical Corps. After the surrender of Winchester to the Confederate Forces in 1862, General Jackson returned all members of the Medical Corps to their divisions, claiming that "since doctors did not make war nor injure soldiers, they would be treated as neutrals, and returned to their divisions."

Unfortunately, not much more was accomplished in the field of medicine after the war. Medical schools requiring little study mushroomed, almost to the same extent the carpetbaggers invaded the South. But with the coming of the twentieth century, great strides could be expected.

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On the Hill: The Washington Scene

AMA Hospital Staff Section Meeting; December, 1985

The hospital staff section of the AMA met for its interim meeting in the nation's capitol this past winter. There is an awesome (my children's favorite adjective) sense of history on Capitol Hill. I found myself winding my way through the Russell and Dirksen Senate Office buildings, traveling the underground tram to the U.S. Senate Galleries, attempting to reflect on the history to be able to endure the future. There was the desk of Daniel Webster, nailed shut to prevent him from slamming it to disrupt the proceedings, the Senate Cloak Room where members of the most exclusive club in the nation sleep on cots during filibusters, and walking past Senator John Stennis of Mississippi in his wheel chair will be permanent recollections. So, of course, will there be less inspiring memories such as Senator Daniel Evans of Washington speaking to a near empty room for TV coverage back home condemning pork barrel water projects in Kansas and the cab driver who did not know where the Capitol was. Perhaps, it was his charge to make me less awestruck. I was there to lobby; lobby I did. We do too little of it; we should and must do more. Perhaps regular leadership trips should be considered but that is another story.

Back to the AMA-HMSS meeting. This was my fourth meeting and I have developed the background necessary to have a perspective of where things are going with respect to the Assembly and the areas of the country represented. We, in Massachusetts, have a special place in the hearts of the Assembly. Upon arrival, we are often solicited by people from all over the country to find out what new attack our Legislature or Governor has bestowed upon us. In attempting to remove all constitutional rights from members of the profession. Once again they were not disappointed.

AMA RESOLUTION 117, was submitted by the HMSS REFERRABLE TO S217 ATTACHING MEDICARE ACCEPTANCE TO LICENSURE. Whereas, the Legislature and the Governor of Massachusetts have enacted Legislation requiring licensure to practice medicine in Massachusetts be contingent upon total Medicare assignment; and whereas, said Legislation is designed to individually identify and publically deny relicensure to physicians choosing not to accept assignment; and whereas, individual physician delicensure under such legislation appears to attack his individual rights under the Constitution of the U.S. as well as individual rights of each of his Medicare patients; therefore be it RESOLVED. That the AMA through its House of Delegates oppose the Massachusetts Legislation which mandates that as a condition of licensure, physicians accept assignment of Medicare cases. Actually, the original resolution proposed by the Oklahoma Delegation called for condemnation of the Massachusetts Legislature and Governor. It was obvious that that great Oklahoman, Will Rogers, never met Mike Dukakis.

AMA RESOLUTION 114: HCFA AND PHYSICIAN PAYMENT. Whereas, HCFA has announced that, effective immediately, they will not require fiscal intermediaries to retrospectively deny payment to physicians when PRO determination is stated that hospitalization is unwarranted; and whereas, HCFA has also announced that where hospitalization has been determined to be unwarranted, they will request physician reimbursement to the government or deduct future payments from physician services; and whereas HCFA also has announced that where a PRO determines that a particular service should have been done as an outpatient service, they will then only pay that part of services which they feel should hve been done as an outpatient and deny to such specialities as anesthesiology, pathology, radiology or physician consultant payments for services when they had absolutely nothing to do with whether the patient was an inpatient or outpatient; and whereas HCFA has further announced that in addition to physician repayment, patients may also be held accountable (if the physician accepts assignment; patient will be held accountable for 20% co-insurance and a $75 deductible; if the physician does not accept assignment, the patient then becomes legally liable for the entire physician charge) for patient payments; and whereas actions by HCFA will lead to increased conflict between physicians and also lead to increased patient confusion, increased patient costs and undoubtedly professional liability; therefore be it RESOLVED, that the AMA urge HCFA to halt retrospective denial of payments until all interested parties have the opportunity to speak to the issue and HCFA develop new guidelines that will be equitable to all interested parties, and be it further RESOLVED that the AMA support legislation pending in Congress that would provide hearing rights for physicians and beneficiaries in cases of retrospective denial in order to assure equitable treatment.

AMA RESOLUTION 115: JOINT VENTURE, RESOLVED, that the AMA study the feasibility of providing services for a fee, to groups of physicians considering joint venture projects; and further, RESOLVED, that this service be designed to provide a detailed evaluation of projects and make recommendations for direction, growth and development.

AMA RESOLUTION 116: LEGAL STATUS OF THE HOSPITAL MEDICAL STAFF, whereas, physicians are privileged to practice medicine in hospitals and are known collectively as the hospital medical staff; and whereas, the medical staff is a formally organized body of physicians who have been approved for hospital privileges by the governing body; whereas the medical staff is entrusted by the governing body with the responsibility for the quality of care within the institution; and whereas, the governing body cannot delegate or supervice functions which it cannot itself exercise; therefore be it RESOLVED, that the AMA office of the general counsel's draft of "legal status of the hospital medical staff."

AMA RESOLUTION 118: INVOLVEMENT IN QUALITY REVIEW AND PHYSICIAN SANCTIONS.

Whereas, HCFA has directed the various state PRO organizations to become involved in quality review functions and potential sanctions of physicians; and

Whereas, this quality review function of the PRO's totally bypasses the inherent responsibility of the organized medical staff to conduct quality assessment and peer review functions; and

Whereas, the organized medical staff should at least have the opportunity to investigate and respond to perceived PRO quality review problems by a member of said medical staff; and

Whereas, this problem is a federal problem in which the various state PRO's are directed to implement the mechanism of conducting quality review and cannot delegate such review to the component medical staffs unless HCFA modifies the PRO contracts; there be it

RESOLVED, that the American Medical Association seek to modify Health Care Financing Administration Professional Review Organization contracts and regulations so that:

1. Any perceived quality review assessment involving a member of a hospital's organized medical staff be first presented for comment and review by the appropriate committee(s) of the organized medical staff; and
2. The organized medical staff should have the opportunity to make appropriate recommendations for corrections, when it deems that it is applicable, before the PRO shall act on a quality review matter; and
3. The organized medical staff shall act and inform the PRO organization in a reasonable period of time concerning what action, if any, was taken in relation to a perceived quality review problem; and
4. The PRO shall be prohibited from taking any further action such as sanctions of a member of the medical staff before such medical staff involvement, review and reporting has been completed.

AMA RESOLUTION 119: HOSPITAL DECISIONS TO GRANT EXCLUSIVE CONTRACTS

Whereas, the Health care delivery environment is being rapidly restructured by public and private sector initiatives to contain health care costs; and

Whereas, Medical staffs are primarily concerned with maintaining individual professionalism and the quality of medical care, and hospitals, on the other hand, are primarily concerned with cost containment and economic survival; and

Whereas, the potential exists for some hospitals to make decisions based solely on economic reasons, such as the granting of an exclusive contract for departmental services, which may ultimately affect the quality of care delivered within the institution and the ability of physicians to continue practicing medicine in that institution; and

Whereas, it must be recognized that the interests of individual medical staff members may differ on such matters; therefore be it

RESOLVED, that the American Medical Association support the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body; and be it further

RESOLVED, that the AMA study and report all legal and other methods which assure that those rights are guaranteed and initiate whatever action is appropriate.

AMA RESOLUTION 120: REPORTING OF INCIDENTS

Whereas, the Department of Health in at least one state has in its regulations that all "incidents" occurring in a hospital be reported by telephone within 24 hours and followed by a written report within five days; and

Whereas, the responsibility for submitting the report is placed in the hands of the administrator of the hospital and "all interested parties," including non-professionals, are also invited to submit reports to the Commissioner of Health; and

Whereas, the information reported can only be classified as allegations; therefore be it

RESOLVED, that the American Medical Association adopt as policy that:

1. All hospital reports mandated by state agencies or outside authorities involving individual physician care of patients should be reviewed prior to reporting by an appropriate medical staff committee;
2. Hospital medical staffs be given a reasonable period of time to evaluate any reports pertaining to a physician's care of patients;
3. The organized medical staff should seek the assurance of the state agency or outside authority that the report will not be subject to public disclosure.
4. Three other resolutions passed by the HMSS at the June 1985 assembly were presented to the House of Delegates at this meeting.

AMA RESOLUTION 1: QUALITY MEDICAL CARE MONITORING: Not to be a permanent part of the hospital medical record.

Whereas, The Joint Commission on Accreditation of Hospitals (JCAH) tries to stimulate quality medical care by monitoring programs; and

Whereas, anything permanently recorded in the patient's hospital medical record is discoverable; and

Whereas, certain hospitals have established progress where reasons for ordering antibiotics is requested by a stamped inquiry on the doctors' progress notes; and

Whereas, the categories "therapeutic" and "empiric" are requested; and

Whereas, any antibiotics adverse effect associated with its use could be used as a basic for compensating proven damages; and

Whereas, the fact-finder may hold the doctor to a higher standard of care when the doctor indicated other than "therapeutic" intent; and

Whereas, quality medical care monitoring should be on a removable form for later compilation and storage as a medical staff record which should be protected; therefore be it

RESOLVED, that the American Medical Association urge hospitals to establish a policy that all medical quality care survey information be protected as privileged, and not become a part of the permanent medical record.

AMA RESOLUTION 2: GOVERNANCE OF THE MEDICAL STAFF

Whereas, American Medical Association policy recognizes the necessity of a self-governing medical staff to the delivery of quality medical care; and

Whereas, certain sections of the Joint Commission on Accreditation of Hospitals (JCAH) Governing Body Standard and Medical Staff Standard weaken the self-governing medical staff; therefore be it

RESOLVED, that the American Medical Association direct its Commissioners to the Joint Commission on Accreditation of Hospitals to seek to affect the following changes in the Governing Body Standards by adding the words underlined and deleting the words lined out as follows:

1. I B. (6) The requirement for the establishment of an organized self-governing medical staff.
2. I M. The governing body acts on recommendations from the medical staff concerning medical staff appointments, reappointments, terminations of appointments, and the granting or revision of clinical privileges

Continued on next page

On the Hill: The Washington Scene

AMA Hospital Staff Section Meeting; December, 1985

Continued from previous page

and such recommendations should be followed unless there is good cause to reject them.

3. I R. The governing body holds the medical staff responsible for the development, adoption, and periodic review of medical staff bylaws and rules and regulations that are consistent with current medical staff practices and with any applicable legal or other requirements.

    1. Medical Staff bylaws and rules and regulations that have been adopted by the medical staff are subject to, and effective upon, approval by the governing body; and such approval is not unreasonably withheld. Such actions by the board shall occur within a time frame mutually agreed on by the medical staff and the board of trustees.; and be it further

RESOLVED, that the AMA direct its Commissioners to the JCAH to affect the following changes in the Medical Staff Standard by adding the words underlined and deleting the words lined out as follows:

1. I A. (1) It includes fully licensed physicians and may include other licensed individuals expressly permitted by law and by the hospitals to provide patient care services independently in the hospital
2. I B. Appointment to the medical staff is made through a hospital-specific mechanism that is initiated, approved and implemented by the medical staff is fully documented in the medical staff bylaws, rules and regulations, and policies; and is described to each applicant. . .
3. I B. (8) The governing body makes the final decision on each application for appointment within a reasonable period of time, as specified in the governing body and the medical staff bylaws.
4. II H. When necessary, the medical staff bylaws and rules and regulations are revised to reflect current medical staff practices.

AMA RESOLUTION 3: PUBLIC EDUCATION OF CHANGES IN HEALTH CARE COVERAGE

Whereas, there are many new health care options available; and

Whereas, some of these options may be attractive due to potential cost savings; and

Whereas, many such departures from traditional health care delivery are untested and experimental; and

Whereas, such options may cause significant dislocations from pre-existing doctor/patient relationships and associated referral patterns; and

Whereas, the patient/client is likely to be an unsophisticated pruchaser of health care packages; therefore be it

RESOLVED, that the American Medical Association assist state and local medical societies to take an active role at the community level to inform the public when changes in health insurance plans are contemplated by employers so that the affected employees can examine the consequences of any such changes.

The interaction between hospitals and hospital medical staffs continues its adversarial course nationwide. It will continue so until the staff is considered a legal entity, a respected coventurer in medical care and not a subservient department.

The continued intervension of the Federal Government into the economics and quality of care of medicine with HHS through disrespectful HCFA idealogues goes on unabated, hopefully, with secretary Ted Bowen this will change.

As more of us educate ourselves to the issues, and enter the political arena, we will have impact. If your hospital does not have a staff section representative, choose one and send him or her to Chicago (Annual-86). Only with an informed staff, can we survive.

Gregory A. Slachta, M.D.
President-Elect
Hampden District Medical Society

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AMA UPDATE — H.D.M.S. Meeting Report

"Will you be a captive or a Captain?" was the challenge thrown to physicians attending the HDMS meeting, January 28th at the Marriott Hotel, by John J. Coury, M.D., the AMA's President Elect. The doctor, who will become President in May of this year, was the featured speaker, and described the many problems confronting practicing physicians today.

He noted the change in the physician-patient relationship through the 33 years of his practice; the tendency to practice "defensive medicine" and the increasingly litigious society. Effective communication to patients was his advice for this.

Decrying the increasing involvement of government and third party payors in medical decisions, he related well to the sympathetic audience as he described experiences with DRG's and PRO's as a surgeon in Port Huron, Michigan. "Be advocates for our patients' good medical care," he urged.

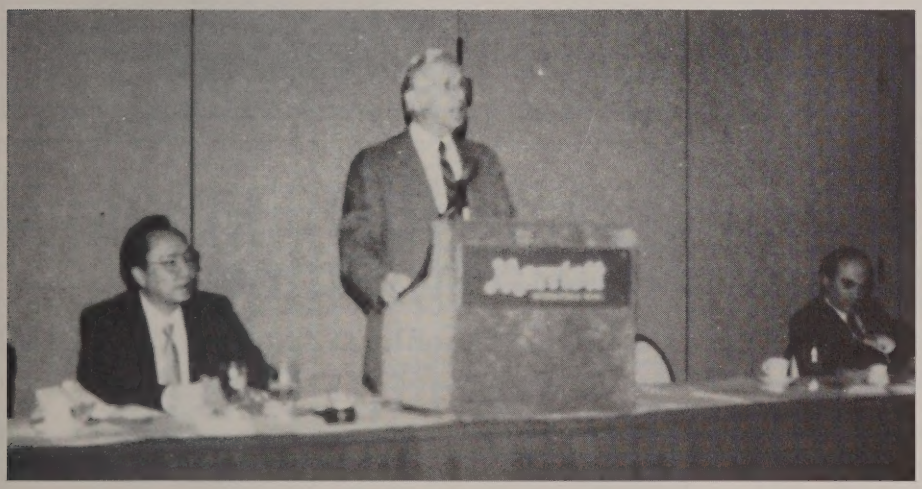
Cost effectiveness in expending medical care was necessary, he felt, but 10% of GNP — the medical care cost in the U.S., was really no greater than that of Canada, Britain, or Sweden if the figures were analyzed properly.

He then outlined professional liability problems and urged support for measures such as the Hatch bill, with the $250,000 cap on "pain and suffering" and the end of "deep pockets" — naming everyone with assets in a suit.

Physicians, faced with restrictions by government, insurors, business and "consumers" may find themselves becoming "indentured servants" if they do not stand up and be counted for "quality care," he maintained. He urged dialogue with these groups, including legislators (there were a significant number present from Western Mass.) Ultimately, he affirmed, we were all interested in the same goal — good medical care for everyone.

Dr. Coury presented as a credible spokesman for "front-line" medicine. His words did echo the address of Dr. Rogers last year. He spoke briefly about the AMA stimulated "Health Policy Agenda" to be made public later this year and felt that it would be invaluable in setting goals and direction nationally in the Health Care arena. We certainly hope so.

W.J. Baker, M.D.



Dr. Coury, American Medical Association President-Elect addresses the Hampden District Medical Society, January 28, 1986.

Dr. Siragusa, Massachusetts Medical Society President-Elect, addresses the business meeting.

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April 14, 1986	"Malnutrition: A National Problem"	George Blackburn, M.D., Assoc. Professor of Surgery, Harvard Med. Schl., Director, Nutrition Support Service, New England Deaoness Hospital, Chief of Nutrition/Metabolism Lab, Cancer Research Institute, New England Deaconess Hospital.
May 12, 1986	"Alzheimer's Disease: Diagnosis and Treatment"	Roy Freeman, M.D., Instructor in Neurology, Harvard Medical School, Assistant Neurologist, New England Deaconess Hospital.
June 16, 1986	"Invasive Radiography"	Melvin E. Clouse, M.D., Associate Professor of Radiology, Harvard Med. School; Chairman, Dept. of Diagnostic Radiology, New England Deaconess Hospital.

Time: 7:30 p.m. CME Credit: 2 Hours category I Springfield Academy of Medicine

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During our severe recession of the early 1980's the American Academy of Ophthalmology realized that many elderly Americans were not availing themselves of the explosion of technological successes in preventing and curing blindness that was occurring in ophthalmology. The reasons appeared to be multiple; 1) lack of knowledge, 2) lack of Medicare coverage (4 to 5% of the elderly), 3) fear that the technology was too expensive in spite of Medicare coverage, and 4) difficulty in obtaining appropriate appointments with ophthalmologists.

The American Academy of Ophthalmology decided to begin to plan a three pronged program to provide medical eye care to the disadvantaged elderly by: 1) promoting awareness, 2) dispersing medical information, and 3) guaranteeing quality eye care. This was to be called the "NATIONAL EYE CARE PROJECT™". Because this was obviously an expensive and time consuming project, a pilot study was planned.

In the spring of 1983 the pilot project was run in the states of Michigan, Washington, and West Virginia. This was promoted by a public endorsement of President Reagan and a media blitz with the help of celebrities such as Gene Kelly, James Mason, and Cary Grant which reached over 30 million people. A toll-free number was announced which the elderly could call for information or help. In a three week period there were over 4,000 calls, 1357 for information plus 2,520 who were eligible for help and were referred to 443 volunteer ophthalmologists. The ophthalmologists and callers were matched by computers. Of the 1,180 who were actually examined, 86% had some type of eye disease (cataracts 59.6%, macular degeneration 18.3%, glaucoma 6.7%, diabetic retinopathy 3.1%). This pilot project was helped by funding and aid of the Mitre Corporation, Apple Computers, Atlantic Richfield, Cooper Vision and Kaiser Aluminum and Chemical Company. Once these results were analyzed and considered successful, the Academy of Ophthalmology made the decision to go forward with the "NATIONAL EYE CARE PROJECT™".

It began January 6, 1986, in Washington state and will be

Continued on next page

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National Eye Care Project™

Continued from previous page

phased in nationwide in two to three week intervals in multi-state regions. Massachusetts will enter the project on June 23, 1986.

The project will operate in this fashion: if a person is age 65 or older, is an American citizen or legal resident, and does not have a personal ophthalmologist, he or she may call a toll-free number for assistance. An operator using a computerized system, will match the caller with a nearby ophthalmologist who has volunteered to provide care.

The project's emphasis is on the needy. If a patient does not have Medicare or other health insurance — and 4 to 5% (more than one million) of elderly Americans do not, for whatever reason — then the physician's services are provided without charge.

If the caller has Medicare or other health insurance, this will pay the entire cost of the physician's services. For this project only, volunteer ophthalmologists have agreed to accept Medicare and insurance assignment as payment in full. (Although this is the law in Massachusetts, it is unique for the rest of America.)

American Academy of Ophthalmology wants to reach as many of these needy elderly Americans as possible. Cataracts, glaucoma, diabetes and other conditions affecting vision need to be detected and treated promptly. In a pilot test of the project, ophthalmologists detected, in addition to eye problems, other medical problems in about 8% of all patients examined. These were referred to other physicians.

In White House ceremonies opening the pilot test, President Reagan termed the "NATIONAL EYE CARE PROJECT™" "voluntarism at its finest." Commendations have come from many organizations and individuals concerned with health care for older Americans.

Funds for the project are coming entirely from the private sector. The project is expected to cost more than $3 million to operate during 1986. About half of the money is coming from voluntary donations from ophthalmologists themselves. The remainder is coming from several major gifts from corporations associated with the eye care profession, and from other individual donors.

The project's services will be available to elderly throughout the nation by midsummer 1986. An intensive media campaign to publicize the toll-free number will be conducted as each region opens. The Foundation of the American Academy of Ophthalmology has made a commitment to operate the project indefinitely, so long as resources and volunteer medical services are available. The goal of American eye physicians and surgeons is to ensure that every old American receives the professional medical and surgical eye care he or she needs, regardless of ability to pay.

The Western Massachusetts coordinator for this project is Joseph Burke, M.D. I am sure there will be sufficient publicity this June to make you aware of the beginning of the project in this state. We will also help to keep you informed through the *Hippocrat.*

Terry D. Ryan, M.D.

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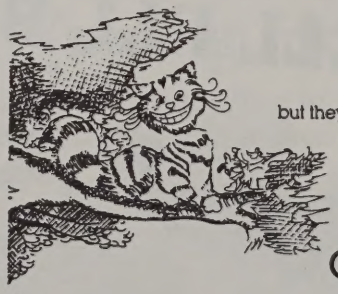

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Gresham's Law in Psychiatric Illness

Recently the Iowa legislature passed a law which deemed a person certified as a health service provider in psychology as qualified to diagnose or evaluate mental illness and nervous disorders and to treat mental illness and nervous disorders, excluding those which are established as having a primarily biologic etiology. This bill was passed with the concurrence of the Iowa Medical Society. One of the psychologists in the state of Iowa termed the new law as "just beautiful" and added that it will provide freedom of choice for consumers seeking care for disorders ranging from alcoholism to autism. Why shouldn't he feel that way? He is now allowed to practice medicine without ever having had to go to medical school.

In fact, psychologists and other professionals interested in mental health are not trained to treat mental disorders. They are trained to do psychotherapy. On occasion, psychiatry practitioners have argued that psychotherapy as practiced by a psychiatrist or psychoanalyst is qualitatively different from that practiced by another mental health professional. However, there are no data to support the idea that "medical" psychotherapy is differentiable from the psychotherapy which is offered by a psychologist, a social worker, a nurse, or, for that matter, a housewife. It takes no great student of law, logic, or evidence to determine that courtroom attempts to support that viewpoint of a qualitative difference are clearly doomed to failure.

So what is the matter with that law that was adopted? According to one medical educator, a physician does only three things which separate him from the rest of the world. He makes complicated diagnoses, he gives potent drugs, and he does surgery. Psychotherapy is often utilized as treatment by physicians, but it does not differentiate them from a multitude of other professionals. But, by giving other professionals the option of diagnosing and treating mental illness and nervous disorders, the legislators in their wisdom have ignored the fact that a good part of treatment is biologic, i.e., pharmacotherapy and other somatic therapies, and that diagnosis is mainly dependent on the concept of differential diagnosis. The psychologist cannot treat mental disorders in the broad sense; he cannot administer drugs. Psychologists can perform psychotherapy, and we may be certain that is what they will use to treat mental illness. But, in some cases the treatment of choice may be biologic. Differential diagnosis is part of a physician's training and may be defined as a diagnosis based on comparison of symptoms of two or more similar diseases to determine from which the patient is suffering. A mental state caused by differing illnesses, both psychiatric and other, is a common circumstance, and it would seem that a medical background would be useful for determining the appropriate diagnosis.

Continued on next page

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Gresham's Law in Psychiatric Illness

Continued from previous page

Almost all of the symptoms seen by a psychotherapist, e.g., depression, anxiety, rage, antisocial activities, and delusions, can be caused by medical illnesses. Further, psychiatric illnesses of all sorts are associated with an increased mortality within a 2-year period of time after psychiatric hospitalization. Death as a result of a variety of medical disorders is twice as frequent as would be expected by chance, and death from suicide is many times as frequent as would be expected by chance. Such findings as these suggest that a medical background in treating and diagnosing mental disorders is valuable. It is possible that a high percentage of the deaths that occur within 2 years by natural causes might occur in people who are admitted with occult medical illnesses. It is also possible that psychiatric conditions themselves may be associated with some lethality.

Interestingly, the bill which was passed allows only psychologists to diagnose and treat mental disorders, but there is no reason to deny social workers, nurses, ministers, and a variety of different kinds of counselors the option to do the same. No evidence indicates that psychologists are better able to do this than other groups. In fact, one can easily make a case for the social worker to be the psychotherapist of the future, because of educational background and number of graduates per year. To carry the circumstance further, having set the precedent, one could make equally as good a case for podiatric nurse practitioners diagnosing and treating disorders of the foot, optometrists diagnosing and treating disorders of vision, and physician's assistants diagnosing and treating internal medical disorders. The concurrence of the Iowa Medical Society in this circumstance may have opened the door for a spate of changes, all of which may possibly rely on the precedent set by the current law involving psychologists.

In a sense, the circumstance is similar to the concept of Gresham's law in economics. This law suggests that when bad money and good money are both present in the economy the bad money will drive out the good. Put more elegantly, if two coins are equal in debt-paying value but unequal intrinsically, the one having the lesser intrinsic value remains in circulation and the other is hoarded or exported as bullion. Probably it is less expensive to offer care using psychologists, social workers, and nurses; and, knowing people as we do, we can expect that they will opt toward the least expensive mode of treatment. However, medical care may not be a simple commodity which can be looked on in dollars and cents terms. It may be something which needs to be protected for community good; and if this is so, one wonders whether this is the right way to go. For all patients, rich or poor, at the very least it seems reasonable to buttress good psychotherapy with an evaluation from a psychiatrist medically trained to perform a differential diagnosis and competent to offer biologic treatment if indicated.

George Winokur, M.D.

This editorial was presented at the 1984 Annual Meeting of the American Academy of Clinical Psychiatrists held in New Orleans, Louisiana in October. Reprinted by Permission

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In accordance with our Constitution and By-Laws to "improve the quality of life through Health Education and services", the Hampden District Medical Society Auxiliary will sponsor its fourth annual Health Education Seminar at Springfield College on Thursday, March 20, 1986.

The focus of this year's seminar will be "Issues in Women's Health: From Menses through Menopause". Six topics will be explored and discussed by area physicians.

The Reproductive Years	Anita Karcz, M.D.
The Mature Years - from the onset of menopause and beyond.	John Zadworny, M.D.
Eating Disorders	Lura Stagg, M.D.
Sexually Transmitted Disease	Robert Hoffman, M.D.
Cosmetic and Reconstructive Surgery - Promises and Pitfalls	Richard Miller, M.D.
Being Fit - Staying Fit	Springfield College
Exercise and Diet	Faculty Member

The courses will run from 9:00 a.m. to 4:00 p.m. with a complimentary lunch served. The cost for the seminar will be $30.00

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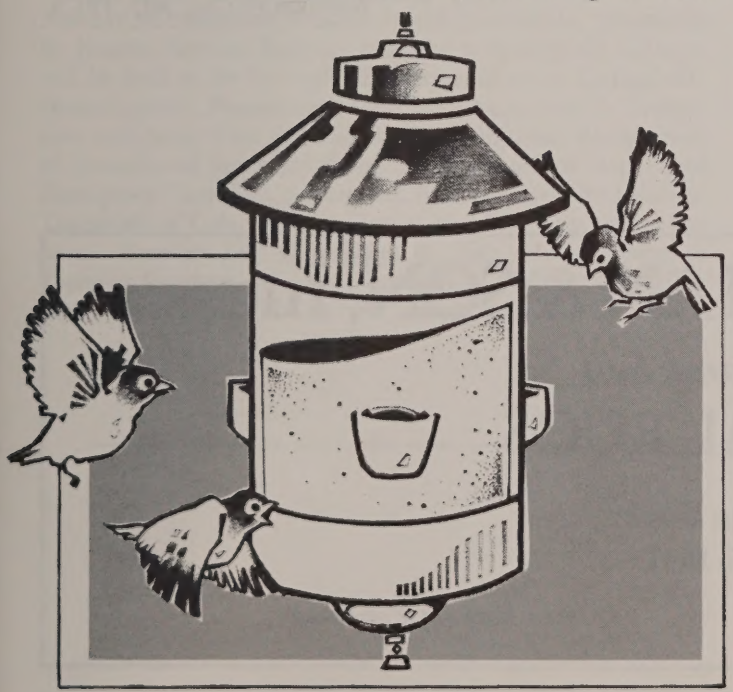

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Fantasy Land II

Prime time television features 13.8 acts of violence per hour. Since the average child watches 27 hours of television per week, by the time he, or she reaches the age of responsibility and assumes control of a lethal weapon, namely a car or a gun, he will have observed some 200,000 acts of violence. On the streets of the United States, there are 150 acts of violence each hour.

It is time the public, both young and old, the latter having presumably graduated to the million — plus violent act class, realized the fallacies of the violence on television, and then perhaps would have a greater appreciation of the reality of the violence on the streets.

In shows such as The A Team, Simon and Simon, and Lady Blue (which has the unenviable honor of being the most violent show on television with fifty acts of violence per hour), good guys and bad guys alike are regularly surrounded by a hail of bullets with virtual impunity. Miami Vice, on the other hand, has made some attempts to depict the reality of violent crime, yet too often the violence of the fusillades is disguised by the addition of music video effects.

Characters who fail to dodge the barrage, although of course avoiding bullets travelling at speeds in excess of 3000 feet per second by ducking or high stepping is to all intents and purposes, impossible, usually follow one or two scenarios. The lucky ones smile bravely while their virtually bloodless wounds are tended by the heroine, while the less fortunate die equally bloodlessly, but are nonetheless able to gasp out those terminal words of wisdom.

More recently, characters have been depicted being thrown backwards by the force of impact, suggesting that producers and directors have finally gone to a physics class. Bullets are imparted at source with tremendous kinetic energy which is dissipated on impact, transferring kinetic energy to the solid tissues such as bone, and destroying soft tissues in the blast path with reverberating shock waves. Gunshot wounds of any kind, small caliber or large, low velocity or high, and especially abominations such as the exploding bullets used in the attempted assination of President Reagan, soft nosed bullets and other missiles that disintegrate on impact, are major injuries, the severity depending on the manner in which the enormous energy is dissipated in the hapless victim.

In the same vein, (although it is interesting to observe that intravenous lines on television rarely enter veins in the locations favored by most Trauma Centers) violent car crashes are commonplace in the same shows, yet despite devasting vehicular demolition, the occupants who never wear seat belts, almost inevitably walk away unscathed. What is never apparent of course, is the fact that the crash is a very carefully scientifically controlled stunt, performed by expert drivers who do wear seat belts, and in fact wear seat harnesses, driving vehicles heavily reinforced with roll bars and other safety adjuncts, and not a production automobile with a driver with no special training.

Finally, one of the most common acts of violence whose lack of authenticity is a constant source of irritation. Since time immemorial characters have been rendered unconscious with a single blow to the jaw or the back of the head, and yet recover consciousness in record time with never a headache, subdural or a broken jaw.

Isn't it time we left fantasy land and recognized violence for what it is, a terrible, devasting cancer in our society. The movie moguls must be induced to understand that violence, if it must be portrayed, should be shown as it really is. We have to stop believing that you can walk away from a totalled car, and that Mr. T can duck bullets, we have to stop idolising Rambo and realize that by now Rocky would be brain damaged. Until violence is portrayed as it really is, the violence will continue.

But maybe it's nicer to live in a fantasy land where Trapper John performs open heart surgery one week and brain surgery the next, all on perfectly made-up, manicured and coiffured patients asleep under mask anesthesia.

Nicholas P. Coe, MD, FRCS.

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Notes and Quotes of Interest

Circle Wednesday, April 30, on your new calendar for 1986. Then tell your staff not to schedule any appointments for you, so you'll be free to spend the day at the Hartford Civic Center enjoying **Medical Expo '86.**

The Expo, the first ever sponsored by the **Hartford County Medical Association,** will combine a medical exposition and educational seminars with a spouse program, special guest speaker, door prizes, cocktail party and the Association's 194th Annual Meeting. We invite you to be our guest from 10 A.M. to 8 P.M. You can look over the new products, question vendors, make business contacts and update yourself at seminars. A special program for spouses will enable you to bring along your spouse, knowing there are special activities planned for both of you, separately and together.

Over 100 exhibitors are expected. You can visit with representatives of pharmaceuticals, medical equipment and supplies, computers and software, surgical equipment, office furnishing, X-ray and diagnostic equipment and medical insurance. You can also see professionals for investment counseling, paging systems, medical office planners, phone systems, lab services, bookkeeping services, medical personnel and much more.

Medical Expo '86 will also be a regional medical event, designed to attract health care professionals from the entire state of Connecticut, Massachusetts and Westchester County in New York. Plan on joining your fellow physicians, hospital administrators, purchasing agents, nurses, technicians and the entire medical community at what we hope will be the premier medical trade show in New England. Contact **Robert Donnell Productions** 1-800-243-9774 (toll free) or (203) 233-3654 in Connecticut for further information.

April 5 and 6, 1986, Springfield, Massachusetts: The 1986 Annual Northeastern Athletic Injury Conference, sponsored by Human Services Training Institute at Springfield College, will be held at the Springfield Marriott Hotel in Springfield, Massachusetts. Presentations and workshops include Evaluation and Acute Care of Head and Neck injuries, Recognition of Dental and Jaw Joint Problems, Medico-legal Aspects of Emergency Care, Recognition and Assessment of Eye Injuries, Transition of Care Athletic Trainer and E.M.T.'s, and many more. Contact I.R. Desrosiers, M. Ed., Human Services Training Institute, Box 1567 Springfield College, 263 Allen Street, Springfield, MA 01109. Telephone 1-413-788-3409.

Community Health Rehabilitation
A Unique Speciality

To function efficiently and effectively within the community health environment, a therapist must be experienced in all aspects of rehabilitation — from neurology to oncology — to orthopedics with a love for working with all ages — because community health is a specialty unto itself. The V.N.A.S., Inc., is proud to employ some of the strongest representatives of the allied health profession and community health care in the greater Springfield area.

The Rehabilitation Department at the V.N.A.S. is composed of a group of young, dynamic, creative individuals who have earned their degrees from top allied health programs such as Boston University, Stanford University, the University of Lowell and the U.S. Navy. Their experience is extensive and diverse, but with specific expertise in athletic training, prosthetics and soft tissue disorders. They are highly skilled at problem solving, consulting with one another, the patient, his/her family, and the physician, to utilize community resources effectively and efficiently to resolve the unique problems faced upon discharge from area hospitals.

The team thoroughly evaluates any patient in his/her home and develops an appropriate treatment plan. This plan may be a one time visit, designed to adapt a home to the individual's needs and to instruct a person in an appropriate exercise program. The treatment plan may also be an intense, extensive rehabilitation program utilizing the therapist's manual therapy skills, movement facilitation techniques, or a variety of current modalities which can safely be performed within the home. During this evaluation, underlying medical problems which may influence the treatment plan, are identified.

A community health therapist must be able to recognize unstable conditions which may contraindicate treatment. In order to appropriately treat an individual therapists must construct an accurate history from information provided by an often, poor historian. In addition, they must be knowledgeable of all rehabilitation disciplines and accept their own limitations in order to facilitate faster patient independence.

The occupational therapist strives to improve perceptual deficits, and promote independence with activities of daily living (A.D.L.'s) in concert with the physical therapist who works to facilitate the normal movement patterns and developmental reactions while gaining the strength necessary to ambulate independently, and bathe or dress independently. Communication is paramount to the success of the physical therapist and occupational therapist; therefore, a speech and language pathologist may be utilized to develop an appropriate mode of communication, or improve existing speech and language patterns.

This sounds very much like the rehabilitation departments that most physicians are familiar with. In many ways it is, but in actuality, home care rehabilitation presents an entirely unique set of problems not encountered in an institutional setting. The hospitalized individual generally returns home to narrow doorways, shag or throw carpets, inaccessible telephones, bathrooms and possibly worst of all — stairs without railings to climb. These are frightening and hazardous situations which have the potential to create dependency in a previously independent person. On site assessment and problem solving is vital to resolve the situation expeditiously.

The V.N.A.S. rehabilitation team plays an integral role in the patient's transition from the hospital to the home. Any individual who needs comprehensive rehabilitation services, and is unable to attend outpatient therapy sessions, is eligible for care. A telephone call to the Agency's Central Intake Unit will initiate the necessary and requested skilled intervention.

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759 Chestnut Street
Springfield, MA 01107 RESIDENT
BORN: August 15, 1959
PREMED: John Hopkins University, Baltimore 1977-81
MEDICAL: University of California San Diego 1981-85
INTERNSHIP: Baystate Medical Center 1985-present time

Roger J. Beneitone, M.D.
444 Montgomery Street
Chicopee, MA 01020
BORN: November 23, 1955
PREMED: Cornell University 1973-77
MEDICAL: SUNY Baffalo 1977-82
INTERNSHIP: University of Connecticut 1982-83
RESIDENCY: University of Connecticut 1983-85
SPECIALTY: INTERNAL MEDICINE

Thomas M. Marantz, M.D.
80 Congress Street
Springfield, MA 01104
BORN: May 7, 1951
PREMED: Antioch College, Ohio 1969-73
MEDICAL: U. Cincinnati College of Medicine 1973-77
INTERNSHIP: U. Cincinnati Medical Center 1977-78
RESIDENCY: Christ Hospital, Cincinnati, 1979-81
SPECIALTY: CARDIOLOGY

Michael A. Marrella, M.D.
55 Broad Street
Westfield, MA 01085
BORN: May 20, 1947
PREMED: St. Peters College, New Jersey 1964-68
MEDICAL: University of Bologna School of Medicine 1968-72
New Jersey College of Medicine, New Jersey 1972-74
RESIDENCY: Bronx Psychiatric Center 1974-76
FELLOWSHIP: Bronx Municipal Hospital Center 1976
Bronx Children's Psychiatric Center 12/1979
SPECIALTY: PSYCHIATRY

Ira M. Nathanson, M.D.
691 College Highway
Southwick, MA 01077
BORN: January 3, 1954
PREMED: Union College, Schenectady, NY 1971-75
MEDICAL: Universita degli Studi di Roma 1977-80
Rush Medical College, Chicago 1980-82
INTERNSHIP: Hinsdale Hospital 7/82-6/83
RESIDENCY: Hinsdale Hospital, Hinsdale, IL 1983-6/85
SPECIALTY: FAMILY PRACTICE

Reed M. Shnider
305 Bicentennial Highway
Springfield, MA 01108
BORN: April 5, 1955
PREMED: Hebrew University, Jerusalem, 1973-1976
MEDICAL: Georgetown University 1976-80
INTERNSHIP: George Washington University Medical Center 1980-81
RESIDENCY: George Washington University 1981-83
FELLOWSHIP: George Washington University 1983-85
SPECIALTY: INTERNAL MEDICINE

Melissa C. Smith, M.D.
444 Montgomery St.
Chicopee, MA 01020
BORN: August 5, 1947
PREMED: Smith College 1965-67
University of MA 1971-73
MEDICAL: University of MA, Worcester 1976-80
INTERNSHIP: Baystate Medical Center 1981-82
RESIDENCY: Baystate Medical Center 1982-85
SPECIALTY: OBSTETRICS/GYNECOLOGY

Charles W. Austin, M.D.
130 Maple Street
Springfield, MA 01103
BORN: July 3, 1951
PREMED: Hanover College, Indiana 1969-73
MEDICAL: Indiana University 1973-77
INTERNSHIP: University of Wisconsin 1977-78
RESIDENCY: University of Wisconsin 1978-81
SPECIALITY: DIAGNOSTIC RADIOLOGY

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In Memoriam

PHOEBE L. COX, M.D.

Dr. Cox, died November 23, 1985. A Mount Holyoke College graduate, she attended both the Mass. General School of Nursing and McGill University School of Medicine, graduating in 1947. She taught anatomy at McGill and was also chairman of the Anatomy Department at Ludhiana University, India. She started general practice in Holyoke in 1960 and retired in 1979.

She leaves two brothers and two sisters. One brother is a HDMS past-president, Gardner Cox.

MILTON SCHIMMEL, M.D.

Dr. Schimmel, died November 7, 1985. He was a graduate of American International and Springfield Colleges, and the Kansas Medical School. Dr. Schimmel was an anesthesiologist at Providence Hospital and was a Longmeadow resident for 30 years. He is survived by his wife, three daughters, and four sisters.

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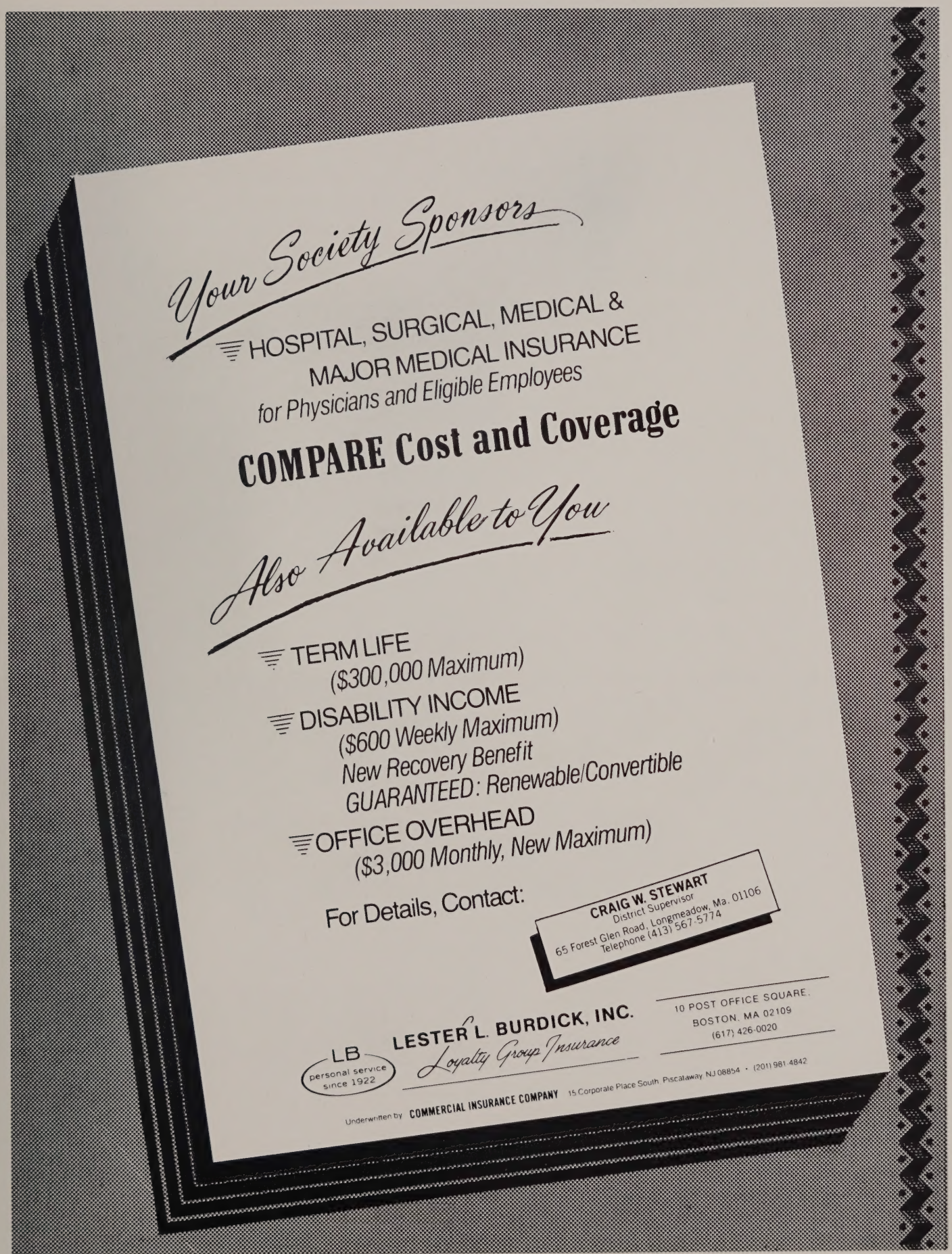
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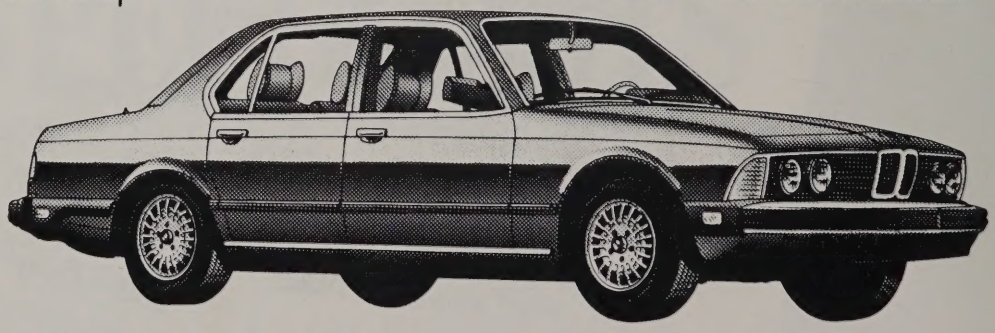

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